U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

2000 Medical Expenditure Panel Survey
Insurance Component
HEALTH INSURANCE COST STUDY
PLAN INFORMATION QUESTIONNAIRE

*Please correct errors in name, address, and ZIP Code.
ENTER number and street if not shown.*

PLAN INFORMATION

FOR CENSUS USE ONLY

100

ENTER THE FIVE DIGIT PLANT NUMBER OF THE ORIGINAL CASE.

For your *(Fill in establishment address from above)* location, please answer the following questions for the health plan with the *(largest/next largest)* enrollment.

1a. For 2000, what was the name of the health insurance plan with the *(largest/next largest)* enrollment of active employees?

012

_____
Name of plan

1b. Is this the same plan as described for a previous location?

☐ Yes
☐ No – **SKIP TO 2**

1c. Are plan premiums and other characteristics about this plan consistent between this location and the one we previously discussed?

☐ Yes – ENTER PLANT NUMBER ABOVE AND **SKIP TO 12a ON PAGE 4**
☐ No

The following questions are about the *(fill in plan name from above).*

2. Was this plan **purchased** from an insurance underwriter or was it **self-insured** by your organization?

105

1 ☐ Purchased from an insurance underwriter (fully insured) – **SKIP TO 5 ON PAGE 2.**

2 ☐ Self insured – *GO TO QUESTION 3 ON PAGE 2.*

FORM **MEPS-10M(S)** (8-3-2001)

PLAN INFORMATION – Continued

3. Was this plan self-administered or did your organization employ an insurance company or other administrator?

106   1 ☐ Self-administered

       2 ☐ Insurance company or other administrator

4. Did your organization purchase stop-loss coverage?

107   1 ☐ Yes

       2 ☐ No   } ***SKIP TO 6***

5. What was the name of the insurance company or carrier providing this plan?

102

Name of insurance carrier

6. Which type of health care provider was available through *(fill plan name)*? Were the providers –

<READ EACH CATEGORY AND MARK (X) ONLY ONE>   DO NOT READ TERMS IN PARENTHESES

103   1 ☐ Exclusive providers the **enrollee must use** in non-emergency situations, (HMO,IPA, EPO)

       2 ☐ Any providers the **enrollee chooses** on a fee-for-service basis, or (CONVENTIONAL, IDEMNITY)

       3 ☐ A mixture of preferred providers and any providers, where the enrollee pays one fee when using a provider associated with the plan and a **slightly higher fee** if he or she goes to a provider **outside the preferred group?** (PPO, POS)

7. Did this plan **require** that the enrollee see a gatekeeper or primary-care physician in order to be referred to a specialist?

104   1 ☐ Yes

       2 ☐ No

FORM MEPS-10M(S) (8-3-2001)

PLAN INFORMATION – Continued

8a. Was **employee-only** coverage offered under this plan?

552   1 ☐ Yes – *Continue with 8b*

  2 ☐ No – ***SKIP TO 9a***

8b. For this plan, how much did one **typical** employee with **employee-only** coverage contribute toward his or her own premium?

132

$ _____ .00   Employee contribution – Employee-only premium

              <MARK (X) ONLY ONE>

623   1 ☐ Weekly   2 ☐ Every two weeks   3 ☐ Monthly   5 ☐ Quarterly   4 ☐ Yearly

8c. What was the *(If self-insured 'monthly premium equivalent', else, 'total premium')* for this **typical** employee with **employee-only** coverage, including both the employer and employee contributions?

130

$ _____ .00   **Total employee-only premium**

<ASK OR VERIFY>

8d. On which of the following time periods are these amounts reported: weekly, every 2 weeks, monthly, quarterly, or yearly?

              <MARK (X) ONLY ONE>

133   1 ☐ Weekly   2 ☐ Every two weeks   3 ☐ Monthly   5 ☐ Quarterly   4 ☐ Yearly

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9a. Was **family** coverage offered under this plan?

137   1 ☐ Yes – *Continue with 9b*

  2 ☐ No – ***SKIP TO 10 ON PAGE 4***

9b. For this plan, how much did one **typical** employee with **family** coverage contribute toward his or her own premium?
READ IF NECESSARY: **If premium varies by family size, report for a family of four.**

136

$ _____ .00   Employee contribution – Family premium

              <MARK (X) ONLY ONE>

624   1 ☐ Weekly   2 ☐ Every two weeks   3 ☐ Monthly   5 ☐ Quarterly   4 ☐ Yearly

9c. What was the *(If self-insured, 'monthly premium equivalent', else, 'total premium')* for this **typical** employee with **family** coverage, including both the employer and employee contributions?

134

$ _____ .00   **Total family premium**

<ASK OR VERIFY>

9d. On which of the following time periods are these amounts reported: weekly, every 2 weeks, monthly, quarterly, or yearly?

              <MARK (X) ONLY ONE>

553   1 ☐ Weekly   2 ☐ Every two weeks   3 ☐ Monthly   5 ☐ Quarterly   4 ☐ Yearly

PLAN INFORMATION – Continued

10. Did this plan have a deductible?

151 ₁ ☐ Yes
₂ ☐ No

11. Which of the following services were covered under this plan for the 2000 plan year:
<READ EACH CATEGORY>

	Yes (1)	No (2)	Don't know (3)
173 Chiropractic care	☐	☐	☐
586 Child preventive care	☐	☐	☐
176 Routine dental care	☐	☐	☐
180 Inpatient mental illness	☐	☐	☐
181 Outpatient mental illness	☐	☐	☐

12a. How many of the ACTIVE employees reported earlier for this location were **enrolled** in this plan during a **typical** pay period in 2000?

125

_____ Active employees enrolled

12b. What percentage of these **enrolled** employees had **employee-only** coverage?

542

_____ % of active employees enrolled in employee-only coverage

OR

129

_____ Number of active employees enrolled in employee-only coverage

12c. Did your organization offer **employee-plus-one** coverage for this plan during 2000?

570 ₁ ☐ Yes – _Continue with 12d_
₂ ☐ No – **_SKIP TO END ON PAGE 5_**

12d. What percentage of the **enrolled** employees had **employee-plus-one** coverage?

621

_____ % of active employees enrolled in employee-plus-one coverage

OR

571

_____ Number of active employees enrolled in employee-plus-one coverage

END

<DO NOT READ ALOUD>

- IF THERE IS A SECOND (OR THIRD) PLAN FOR THIS ESTABLISHMENT – GO TO ANOTHER MEPS-10M(S) QUESTIONNAIRE FOR THAT PLAN.

- IF YOU HAVE ALREADY COLLECTED INFORMATION FOR THREE PLANS FOR THIS ESTABLISHMENT – GO TO THE MEPS-10M QUESTIONNAIRE FOR THE NEXT ESTABLISHMENT.

- IF THERE ARE NO MORE PLANS FOR THIS ESTABLISHMENT – GO TO THE MEPS-10M QUESTIONNAIRE FOR THE NEXT ESTABLISHMENT.

- IF THERE ARE NO MORE ESTABLISHMENTS – END THE INTERVIEW BY READING THE THANK YOU STATEMENT.

- REFER TO MEPS-10M, PAGE 4 – HAVE RETIREMENT QUESTIONS BEEN ANSWERED?

THANK YOU

This concludes the Health Insurance Cost Study. Thank you very much for your time and cooperation.